ERAS and Ambulatory Surgery Session

12.9.2025

Implementation of ERAS in Latin America

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Conflict of interest

- Medtronic speaker

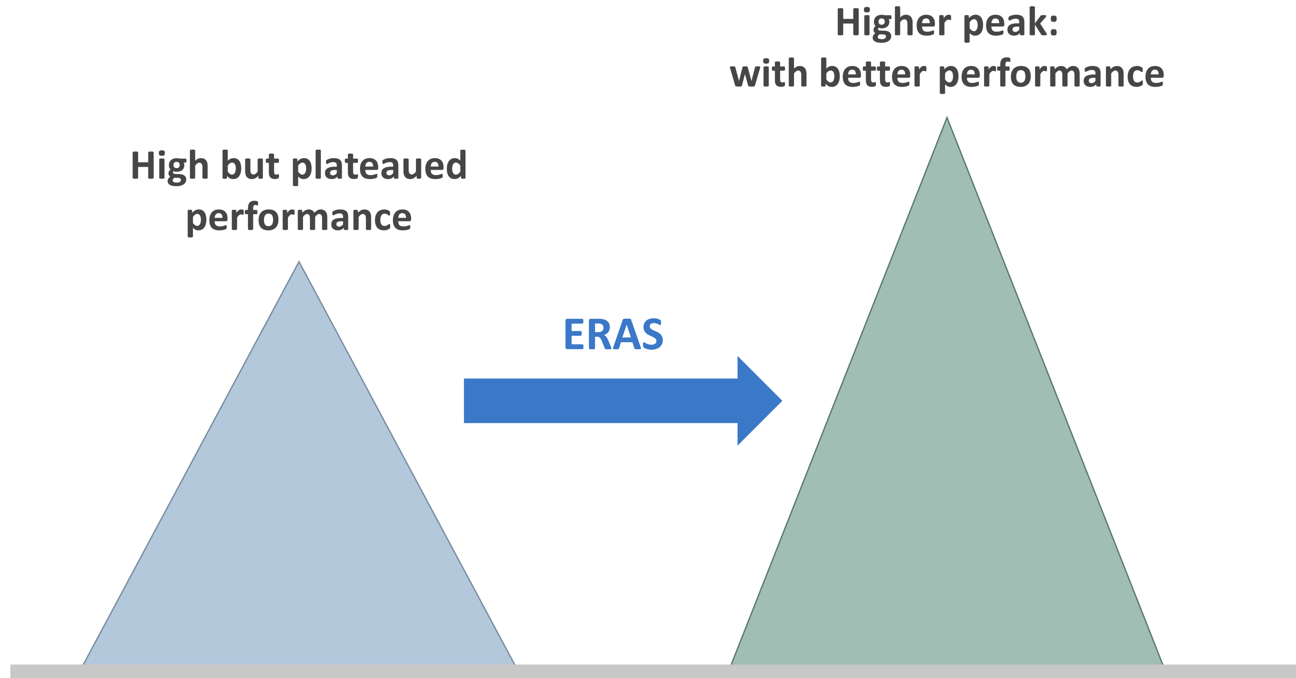
PERSONAL BEST

By Atul Gawande

September 26, 2011

“No matter how well trained people are, few can sustain their best performance on their own. That’s where coaching comes in”

We are good, but we can do better



Can we improve outcomes in bariatric surgery?

- Why outcomes matters and to whom?
  - **Patient**
    - faster and safer recovery
    - less pain and nausea
    - shorter hospital stay
  - **Surgeon**
    - fewer complications
    - enhance safety and consistency of results
    - measurable performance
    - reputation and trust
  - **Institution**
    - lower cost and length of stay
    - fewer readmissions
    - better quality indicators
  - **Health insurances**
    - know cost
    - low cost
    - safe procedures

What outcomes should we measure?

- What do we mean by ¨better outcomes¨
  - less complications
  - shorter length of stay
  - less 30-day readmission
  - no mortality
  - increased patient satisfaction
  - less nausea/vomits
  - less pain/Opiods use
  - lower costs

ERAS targets all of them

What is ERAS?

- **Enhanced Recovery After Surgery (ERAS)** is a multimodal, evidence-based approach to optimize perioperative care and recovery.
- **Standardized care organize in 4 stages:**
  - preadmission: patient education and engagement
  - preoperative: shortened fasting, carbohydrate loading, premedication
  - intraoperative: minimally invasive techniques, analgesia, fluid volumes
  - postoperative: early mobilization and feeding

*continuous audit and adherence monitoring

Evidence supporting bariatric ERAS

- **What the data show:**
  - ↓ length of stay (by 1–2 days on average)
  - ↓ complications (up to 50–70% in some studies)
  - ↓ readmission rates
  - ↓ opioid use and pain scores
  - ↑ early ambulation and feeding
  - no increase in serious adverse events

but how many of us are actually applying it?

Journey to Bariatric ERAS Program Certification

First seminar
August

2023

2024

Second seminar
March

First ERAS patient
April 1

2024

2025

April
First year ERAS
(n=101)

Before and after ERAS: what we have accomplish

Compliance area	Pre ERAS	ERAS	p value
Preadmission	23.5%	52.9%	$p <0.01$
Preoperatory	72.5%	81.3%	$p <0.01$
Intraoperatory	71.1%	84.3%	$p <0.01$
Postoperatory	59.4%	88.8%	$p <0.01$

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Clinical impact of first year of ERAS

Variable	Pre ERAS (n=51)	ERAS (n=101)	valor p
Female	76%	70%	p ns
SG	69%	60%	p ns
RYGB	31%	40%	p ns
Age	39.8 11	38.3 ± 5	p ns
BMI	34.8 ± 5	35.7 ± 5.2	p ns
LOS	1.18	0.85	p 0.0134
Clavien > 3b	2%	2.35%	p ns
Nausea	32%	7.8%	p <0.001
Pain	3.8%	3.8%	p ns

Over 90%
of SG cases discharge
same day of surgery

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Why centers don´t pursue official certification

- Many barriers, specially in latin america
  - **cost**: software licensing (EIAS), coordinator roles
  - **time:** training, weekly meetings, educate time, protocols
  - **human resources**: need for dedicated team
  - **institutional and staff inertia**: resistance to protocolization

Bariatric Surgery ERAS Centers Worldwide

Australia - St Vincent
Singapore - Tan Tock Seng Hosp
France - Centre Hospitalier d Argenteuil
France - CHRU de Besancon
Italy - Campus Bio Medico
Italy - Ospedale Santa Maria
Italy - Ospedale Classificato Equiparato Sacro Cuore
Portugal - Centr Hosp Uni Coimbra EPE (CHUC)
Switzerland - Hopital du Valais Sion
Switzerland - Osp.Regionale Locarno
Chile - Clinica Universidad de los Andes

Chile - Red Salud/Clinica Bicentenario SpA Santiago

* data provided by ERAS society

Some ERAS is better than no ERAS

- Why start, even if you can´t certifiy (yet)?
  - faster recovery for patients
  - reduced complications and readmissions
  - shorter length of stay
  - better patient satisfaction
  - builds teamwork and standardization culture
  - creates baseline data to justify future certification

Formal versus informal ERAS programs

Aspect	Informal / Uncertified ERAS	Official ERAS Certification
Adherence to guidelines	Partial, variable between professionals	Complete, standardized according to ERAS® guidelines
Auditing & benchmarking	No structured auditing, no external comparison	Continuous audit via EIAS, with global benchmarking
Institutional support	Dependent on individual champions	Strong institutional commitment and multidisciplinary buy-in
Sustainability	Vulnerable to staff turnover or loss of key advocates	Embedded in institutional processes, sustainable over time
Recognition	Limited to local awareness	International recognition as ERAS® Center of Excellence
Team culture	Some standardization, but inconsistencies remain	Fully standardized perioperative pathways
Professional development	Limited opportunities for formal ERAS training	Access to ERAS® network, training programs, and collaborative research

ERAS in latin america

- Certified programs are still **rare** in the region
- Cost is the main barrier
- Many centers apply “ERAS-like” measures with positive results
- **Ideal path:** Start small → measure → demonstrate success → scale to certification

Conclusions

- Certified programs are **still rare** in the region
- **Cost** seems to be a great barrier
- ERAS improves **patient safety**, **recovery speed**, and **overall outcomes** in bariatric surgery.
- Benefits extend beyond patients — surgeons and institutions also gain.
- We all can achieve a higher peak of performance, we can have our own personal ¨institutional best¨

Thanks to our team at Clinica UANDES

Enf Coordinadora
Pilar Hevia

Equipo Obesidad y Diabetes

Equipo ERAS Cirugía Bariátrica

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